the bleeding, applied ice and went to bed. This morning there was blood on the pillowcase, the pain had intensified, and my vision was blurred. I reasoned this required an objective medical evaluation to ensure there was no permanent damage. Thus began my hassle for the day.

What followed was more than a dozen telephone calls to various medical professionals and administrators to get permission to go to the doctor and secure the required referral for them to be paid. I knew what had to be done, but what is the justification for wasting my time and causing me anxiety and aggravation? As a professional, if I am not working, I am not being paid. Consequently, the very real financial loss I endure by sitting in a waiting room makes me choose the medical visit option only as a last resort.

That day I wasted additional time and resources playing phone tag all around the State trying to get some paperwork-pushing clerk to give me permission to do what I knew to be right. And, by the way, we pay for this, which is what truly amazes me.

What should we do? I suggest we all write to our State and Federal elected officials demanding that they return the right of self-determination in health matters to us by passing the Patients' Bill of Rights and similar state statutes. It is no wonder the doctors are unionizing. Perhaps the patients should too.

He was talking about an eye injury, but we just know that with the case of eye injury or so many other serious problems that people face the same reality.

All I am really saying tonight, Mr. Speaker, because this may be the last opportunity we get to talk about this before the August break, is let us bring up the Patients' Bill of Rights. Let us bring up HMO reform. Let those Democrats and those Republicans, and I see my colleague is going to come after me, the gentleman from Iowa (Mr. GANSKE), let us put together a bill I think that is very close to the Patients' Bill of Rights that really provides comprehensive HMO reform. This is what the public wants, this is what we keep hearing every day from our constituents, and I know that I am going to use the time during this August break to go out and explain to the public why we need to bring this up on the floor of the House when we come back in September.

I am confident when I see people like my colleague, the gentleman from Iowa (Mr. GANSKE) and others on the Republican side that are demanding that we take action, that when we come back in September, either through the means of a discharge petition or because the Republican leadership finally sees they have to do something, that we will see comprehensive HMO reform. But I am not going to rest, and I know the gentleman from Iowa (Mr. GANSKE) and a lot of us are not going to rest until that happens.

MANAGED CARE REFORM

The SPEAKER pro tempore (Mr. VITTER). Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized for 34 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, here it is, about 11:30 p.m. in Washington, and our families will be happy to know that we are here on the floor, taking care of the country's business. I wish to speak for the remainder of this evening about managed care reform. One of these days we are going to pass this, and my friend from New Jersey and I will maybe have to stop passing like ships in the middle of the night, coming to the floor to speak about this issue.

But, Mr. Speaker, it has become I think commonplace knowledge that we have problems with managed care in this country. That is recognized by a lot of the humor that we see in the country.

Several years ago, a joke started going around the country about the three doctors who died and went to heaven. The first doctor was a neurosurgeon. St. Peter asked him, ''What did you do for a living?'' He said, ''I took care of victims of automobile crashes who had injured their heads and tried to get them back to a normal life.'' St. Peter said, ''Enter, my son, and enjoy heaven.''

The next doctor who came up to the pearly gates was asked by St. Peter what he did. He said, ''I was a heart surgeon and I took care of people who were having heart attacks and managed to prolong their lives so that they could spend them with their families.'' St. Peter said, ''Enter, my daughter, and enjoy heaven.''

The third doctor who came up to the Pearly Gates was asked by St. Peter, ''What did you do?'' He said, ''Well, I was an HMO manager.'' St. Peter kind of stroked his beard and he said, ''Son, you may enter, but only for 3 days.''

Now, everyone has heard that joke. Why is that funny? Well, number one, because there is a kernel of truth in it and there is a twist. All of us who have had to deal with managed care, and as a physician I certainly have in advocating for my patients, knows that managed care has put severe time limits on whether patients can stay in the hospital. We will talk about some of those examples.

So now it is sort of funny that this HMO manager is going to get his comeuppance. I think that is part of the humor.

The humor of HMOs, in order for something to be humorous, people have to understand the underlying point. So let us just look, for example, at some of the cartoons that we have seen around the country.

Here is one. We see a doctor sitting at a desk. He is reading a paper. Behind him is an eye chart that says ''enough is enough,'' and the doctor is saying, ''Your best option is cremation, $359 fully covered.'' The patient, sort of nonplussed, is sitting there saying, ''This is one of those HMO gag rules, isn't it doctor?''

Now, this is a little harder to see for my colleagues here in the audience tonight. I will have to read this to you. Here is a physician sitting behind his desk. He is talking to a patient. The physician is saying, ''I will have to check my contract before I answer that question.''

Now, what is the point of this cartoon? Well, about 3 years ago it became known that HMOs were writing contracts that required the doctor to check with the HMO before they told the patient all their treatment options. Now, think about that.

☐ 2330

Let us say that one is a woman, one has a lump in one's breast, one goes in to see one's doctor. One's doctor takes one's history, does one's physical exam, and then says, ah-hah, excuse me, and steps outside, gets on the phone to the HMO and says, ''Mrs. So-and-so has a lump in her breast. She has got three treatment options. One is more expensive than the other. Is it okay if I tell her what her three options are?''

I mean, that is awful. As a practicing physician in solo practice for 10 years after medical school and residency, I can tell my colleagues, that the doctor-patient relationship will not stand that type of restriction on communication.

Patients have to trust their physician to be able to tell them the whole story. It may be that the HMO is not going to cover part of the treatment or one of the options, but the patient has every right to know what all the options are at a minimum.

Then we start to get into some things that are a little less than funny on an issue like this. Here is a headline from the New York Post: ''What his parents did not know about HMOs may have killed this baby.'' Now, here is an infant that died possibly because his HMO prevented his physician from communicating to his parents the entire story. It is not so funny anymore.

Let us go to the case of a lady whose story was covered in Time Magazine a couple years ago, well documented. This lady is no longer alive. Her HMO made a medical decision to try to limit her and her family, her husband, from knowing all of her treatment options. They put a lot of pressure on the medical center to prevent and actually change their opinion on what kind of treatment this patient should have.

This lady could be alive today as a mother to her children and a wife to her husband had not that HMO made a medical decision that limited the information that she got. Not so funny anymore.

So what happened? Well, I and the gentleman from Massachusetts (Mr. MARKEY) in a bipartisan fashion reached across the aisle, and we got about 285 co-sponsors to sign a bill called the Patient Right To Know Act. This was about 3 years ago now, 285 bipartisan co-sponsors.

We discussed some suspension bills here tonight. Just with the cosponsors alone, we could have brought that to the floor and passed it under suspension. Not to be. I could not get my

leadership to allow that limited bill with such widespread bipartisan support to handle the problem that HMOs were limiting communications between the doctors and their patients. I could not get the leadership to allow that to be voted on and debated on the floor.

Well, let us go back to some of the humor that has gone on about HMOs. Remember the movie ''As Good As It Gets''? I went with my wife to this movie in Des Moines, Iowa, and something happened I had never seen before. When Helen Hunt was describing the care that her HMO gave in the movie to her asthmatic son, she expressed a rather strong expletive about her HMO and the treatment she was getting for her son. It elicited a lot of laughs in the audience.

But something else happened that I had never seen in a comedy in a movie theater. Some people stood up and clapped. They actually started clapping for her strong statement of disapproval about the way her son was being treated. Now, that does not happen. Humor like that is not effective if it is not understood and if it doesn't strike a nerve and a cord. But it sure did in that movie.

Now, she was having problems with her son getting care and was frequently having to take him to emergency rooms.

Here is another cartoon, sort of, that I saw. Here is a nurse on the phone. I think this is from an old TV show, this picture. She is saying, ''Chest pains? Well let me find the emergency room preapproval forms.''

What is one of the other problems that we have seen with HMOs? Well, it happens to be that a lot of HMOs, a few have refused to pay for emergency room visits. Let us say a patient gets a chest pain, severe crushing chest pain. The American Heart Association says this is a sign one could be having a heart attack.

One's wife takes one to the emergency room. They do the EKG, but it is normal. They find out that, instead, one has severe inflammation of one's esophagus and one's stomach instead.

Afterwards, what does the HMO do? They say, ''See, your EKG was normal. You were not having a heart attack. You did not need to go to the emergency room. We are not going to pay for it.''

What is the lessen that people start learning from that? Gee, maybe if the HMO is not going to cover these things that the common layperson would say is an emergency, maybe I should just take my time a little bit. Except that we know, when that happens, a certain number of people die before they get to the hospital.

Now there certainly is such a thing as black humor, and this cartoon has some of the blackest humor I have seen. What we have here is a medical reviewer at an HMO, and I am going to read this for my colleagues. She is speaking on the telephone.

She says, ''Cuddly Care HMO. My name is Bambi. How may I help you?''

She continues speaking on the phone. ''Oh, you are at the emergency room and your husband needs approval for treatment. He is gasping? Writhing? Eyes rolled back in his head? It does not sound all that serious to me.'', she says.

Far side. She says, ''Clutching his throat? Turning purple? Uh-huh. Have you tried an inhaler? Oh, he is dead? Well, then he certainly does not need treatment, does he?''

Her last comment is, ''People are always trying to rip us off.''

Pretty black humor.

But let us talk about a real case. Let us talk about this young woman who, about a year and a half ago was hiking in the Appalachian Mountains. She fell off a 40-foot cliff. She was lying at the bottom of that cliff with a broken skull, a broken arm, a broken pelvis, semi-comatose, almost drowning in a pool of water.

Fortunately, her boyfriend was able to get an air ambulance in. They took her to the hospital. Here she is all bundled up on the stretcher going to airlift her to the hospital.

She makes it to the hospital emergency room. She is stabilized. She is treated. She is in the hospital for a month or so, in the ICU for a couple of weeks. She is on a morphine drip. Those are pretty painful problems that she had. Plus she has broken her head. She has got a fractured skull.

What happens to this young woman? Her HMO refuses to pay the bill. Now, why is that? Well, the HMO said that she did not call ahead for prior authorization. I mean, think of that. She was supposed to know that she was going to fall off this cliff. Maybe when she is lying at the bottom of the cliff with the broken skull, a broken arm, and a broken pelvis, she is supposed to reach into her coat pocket with her nonbroken arm, pull out a cellular phone, dial a 1–800 number and say, ''Bambi at that HMO, I have a broken skull. I need to go to the emergency room. Is that okay?''

□ 2340

I mean that is the type of thing that we do not need to see; that we need to fix. And we need to fix it because Congress passed a law about 25 years ago called ERISA, and what it did for employer plans was it took them out of State oversight.

State insurance commissioners and State legislatures, they do not have much to say about plans that are offered by employers. We talk a lot as Republicans about devolving power back to the States, but I have not seen my leadership too much interested in making sure that the States can provide proper oversight for health plans.

And so we have this law that Congress created that basically left a vacuum. State insurance commissioners cannot tell a plan, like that woman who fell off the cliff, they cannot tell her plan, if she is in an employer plan, that they have to cover her services. Those plans have been exempted from State oversight. Congress made that problem; Congress needs to fix it.

Let us look at a few other cartoons that have been in the press. Here is one called the HMO bedside manner, and we have an individual lying there with broken arms, in traction. And on the wall is the HMO bedside manner, and it says, ''Time is money. Bed space is loss. Turnover is profit.'' And then we have a physician at the bedside saying, ''After consulting my colleagues in accounting, we have concluded you're well enough. Now go home.''

Or how about this one. ''Remember the good old days, when we took refresher courses in medical procedures,'' this doctor is saying to a colleague. Now they are going into the HMO medical school and the course directory for the HMO medical school is, first floor, basic bookkeeping and accounting; second floor, advanced bookkeeping and accounting; third floor, graduate bookkeeping and accounting.

Now here we have another example of the HMO emphasis on bottom line profits versus taking care of the patient. This is the HMO claims department, and we have a claim's reviewer saying into her telephone, ''No, we don't authorize that specialist.'' Then she goes on, ''No, we don't cover that operation.'' Then she says, ''No, we don't pay for that medication.'' Then, apparently the person on the other end of the line says something where she kind of jerks, and she says, ''No, we don't consider this assisted suicide.''

How about this cartoon that appeared in the Boston Globe. We have an HMO doctor here and the patient is saying, ''Do you make more money if you give patients less care?'' The HMO employee says, ''That's absurd, crazy, delusiona.'' The patient comes back and says, ''Are you saying I'm paranoid?'' The HMO employee says, ''Yes, but we can treat it in three visits.''

Now, my colleagues may think that this is kind of funny, but as a plastic and reconstructive surgeon, I took care of a lot of patients with this type of defect. This is a little child born with a cleft lip and a cleft palate. Now, the standard treatment for correction of this child's cleft palate is a surgical repair. That gets the roof of the mouth together so that this child can learn to speak normally. It also keeps food and liquids from going out his nose. That is standard treatment.

Do my colleagues know what some HMOs are doing now? They are writing into their contract language a definition of medical necessity that says we will only authorize payment for the cheapest, least expensive care. Under Federal law they can do that and nobody can challenge it because that is written into their contract.

So what does that mean for a little baby that is born with this type of defect? It means that that HMO, under Federal law, could tell the parents that they are not going to cover surgery; that they are just going to provide

their child with a little piece of plastic to kind of shove up into the roof of his mouth that will kind of fill in that hole.

Of course, if baby spits it out, that does not matter. If baby chokes on it, I guess that could be a problem. And, of course, the baby will not be able to learn to speak normally, and eventually will continue to have problems with food coming out of his nose. But under current Federal law, the current Employee Retirement Income Security Act law, that HMO can write that medical definition any way they want.

Not exactly the best way to take care of patients, and one of the reasons why we need to do something to fix that.

Now, I just read this. This is from the Albany Times Union. Here is another emergency room story, and this is about a lady by the name of Elsa Goldstein. She had a medical emergency one night. She went to the hospital emergency room. She was given a medication in the hospital by the emergency room doctor. She was supposed to take the medicine twice a day. So she went to the local pharmacy where she has coverage through her HMO, but the pharmacy would not provide her the medicine. They wanted to charge her $109 for the medication.

So she said, why is that? I mean my insurance company is supposed to pay for this, is it not? And she was told, yes, but only if the HMO doctor writes the prescription. She said, well, wait a minute, I was in the emergency room. This was an emergency room doctor who wrote me the prescription. My HMO doctor's office is closed. It is in the middle of the night and I need that medication. The response was, sorry, you cannot have it. You can pay for it yourself.

And then she got on the phone with an HMO representative who said, oh, just take this medication, this over-the-counter medication. Funny thing about this, though. This Elsa Goldstein happened to be a physician herself, and the medication that this HMO bureaucrat was prescribing over the telephone she knew would have been detrimental to her health.

This is the type of stuff that goes on all of the time. Here is another one of these cost-cutting mechanisms. What did that HMO try to do? They tried to just dun this patient. If they do it enough, enough people will just give in, they will just buy it on their own and then the HMO just makes more money.

Now, what did the HMOs come up with as a great idea a few years ago? Remember this? Remember when they were saying, oh, people can just go to the hospital and go home right away?

☐ 2350

In fact, we are going to mandate those sort of drive-through deliveries. So here we have a picture of the maternity hospital and we have here the drive-through window. Now only 6-minute stays for new moms. ''Congratulations. Would you like fries with that?'' And you have this as far as the woman in the car holding her newborn baby ready to drive through and drive out.

By the way, this was the result of one of those Milleman and Robertson guidelines that the HMOs like to use that they like to flaunt as their solutions.

How about Dr. Welby? Now maybe he would be saying, she had her baby 45 minutes ago; discharge her.

Once again we are getting into a little bit more black humor. Because here we have the operating room. We have the doctors here. And the doctor is saying, ''scalpel,'' and the HMO bean counter says, ''pocket knife.'' And then the doctor says, ''suture,'' and the HMO bean counter says, ''Band-Aid.'' And the doctor says, ''Let us get him into intensive care.'' And the HMO bentonite says, ''Call a cab.''

But here is a real story, front page headlines, New York Post: ''HMO's Cruel Rules Leave Her Dying for the Doc She Needs.'' All of a sudden it is not so funny anymore. Because now we have a picture of a person who has probably lost her life because of an HMO medical decision, which, by the way, under Federal law, an employer plan is not liable for the consequences of their medical decisions other than providing the cost of care not delivered. And if the patient happens to die early, then they are not responsible for anything.

Well, Mr. Speaker, it is getting kind of late, so I want to talk about two more patients. I want to talk about a conversation I had about a year ago with a pediatrician who worked in the Washington, D.C. area. She is now doing research at one of the national labs.

I asked her why she left the practice of medicine. She was a pediatric specialist in a pediatric ICU. And she said, Well, I just got past the point of being able to deal with those HMOs anymore. But the straw that really broke my back was one day we had come into the intensive care unit a 5- or 6-year-old boy who had been drowning. He was still alive but just barely. We had him hooked up to the ventilator. We had him plugged into the IV. We were giving him all the medicine that we could to try to save his life. We were standing around the bedside. It was not looking good. But we were expending every effort to try to save this child's life. And the phone rings in the ICU and it is some HMO reviewer a thousand miles away wanting to know about the case, probably looking at a computer screen and an algorithm, and the questioning went sort of like this:

Well, tell me about this young patient. Oh, he is on the ventilator. Well, what is his prognosis? The doctor says, well, it is not too good. We are trying to do everything to save his life. He has only been here an hour or so.

This HMO reviewer from a thousand miles away, never having seen this patient, then says this incredible thing, probably looking at that computer screen, on the ventilator, poor prognosis. Next suggestion from the HMO, one of these HMO guidelines: Well, if his prognosis is so bad, why do you not just send him home on a home ventilator?

Now, for anyone who has any medical experience on this, that would make the hair on the back of their head stand up. If that little child is going to survive, he is going to need every ounce of expertise and skill from a whole team of nurses and doctors. And for this medical reviewer to say send him home on a home ventilator is a death sentence.

What is the motivation behind it? To save a few bucks.

I am going to close with one story. This is a story about this little boy right here. You see him tugging at his sister's sleeve. When he was about 2 months old, about 3 in the morning he was pretty sick. He had a temperature of 104. And as mothers can tell, he needed to go to the emergency room.

So his parents lived south of Atlanta, Georgia. His mother does the thing that the HMO says, phones the 1–800 number, gets a distant voice from somebody who has never seen this little boy. He says, Well, I will let you go to an emergency room, but I am only going to let you go to this one emergency room which is more than 65 miles away. That is all I will authorize. That is the only one we have a contract with, to save money.

So Mom and Dad, they are not health professionals, they wrap up little Jimmy in a blanket. They get in the car. Dad starts driving. They are halfway there, and they pass three other hospital emergency rooms they could have stopped Jimmy at. But they do not have authorization. They are not health care professionals. But they do know if they stop unauthorized they will be stuck with potentially a very large bill.

So they follow the medical decision that that HMO reviewer made and push on. Except that before they get to the hospital that Jimmy is supposed to go to, he has a cardiac arrest. His eyes roll back in his head. He stops breathing. His heart stops. And his mom tries to keep him alive. They pull into the emergency room.

Mom leaps out of the car with this little baby, screaming, save my baby. Save my baby.

A nurse comes out gives him mouth-to-mouth resuscitation. They bring the crash cart out. They start the IVs. They give him the medicine. And they manage to get him going again. They manage to save his life.

Unfortunately, they do not manage to save everything on Jimmy. Because of that cardiac arrest from that decision that that HMO made, Jimmy ends up with gangrene of both hands and both feet and the doctors have to amputate both hands and both feet.

Here is a picture of little Jimmy today. In order to save as much length

on his arms and his legs, they put skin grafts on after they amputated his hands and his feet.

I talked to his mom about a month ago. Jimmy is now learning to put on his bilateral leg prosthesis. But he still needs a lot of help on getting on his bilateral hook prosthesis.

This little boy will never play basketball. I will tell the Speaker of the House that that little boy will never wrestle. When this little boy grows up and marries the woman that he loves, he will never be able to caress her cheek with his hand.

Do my colleagues know what the opponents of this patient protection legislation say? They say this is just an anecdote; we should not legislate on the basis of anecdotes.

I would say to them, this little anecdote, if he had a finger and you pricked it, it would bleed. And do my colleagues know that, under Federal law, that HMO which made that medical decision is liable for nothing.

Is that justice? Is that fair? We need to change that law to encourage HMOs not to cut corners like this so that we do not end up having to cut off hands and feet.

A judge reviewed this case and the HMO's decision and came to the determination that that HMO's margin of safety was ''razor thin.'' I would add to that, as razor thin as the scalpel that had to amputate little Jimmy's hands and feet.

My colleagues, as my colleague from New Jersey pointed out, for years now we have been trying to get this to the floor for a fair debate. We had a rigged debate last year with a fig leaf bill.

I am telling my friends on both sides of the aisle that there are Republicans and there are Democrats that have come together and we are working on a bipartisan bill. We will introduce that soon, and we will do everything we can with more than a majority of the Members of this House to bring this to the floor and to correct these types of abuses.

I would encourage my friends on the Republican side of the aisle to contact myself or the gentleman from Georgia (Mr. NORWOOD), the Georgia bulldog, who has done as much as anyone to advance this, or my friends on the Democratic side of the aisle, to contact the gentleman from New Jersey (Mr. PALLONE) or the gentleman from Michigan (Mr. DINGELL) and get on board this bipartisan effort.

The only way we are going to solve this is to work together, both Republicans and Democrats, put aside partisan differences, and fix this for the people in our country.

CORRECTION TO THE CONGRESSIONAL RECORD OF MONDAY, AUGUST 2, 1999, AT PAGE H6810

REQUEST FOR CONSIDERATION OF S. 1467, EXTENSION OF AIRPORT IMPROVEMENT PROGRAM

Mr. SHUSTER. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill (S. 1467) and ask for its immediate consideration in the House.

Mr. OBEY. Mr. Speaker, I object.

The SPEAKER pro tempore. The Chair is not able to entertain the gentleman's request at this time.

Mr. SHUSTER. Mr. Speaker, the gentleman from Minnesota (Mr. OBERSTAR), I understand, is reserving the right to object.

The SPEAKER pro tempore. The gentleman from Pennsylvania (Mr. SHUSTER) is not recognized for that purpose.

Mr. SHUSTER. May I ask why the gentleman is objecting? Is it in order, Mr. Speaker, for me to ask why the gentleman is objecting?

The SPEAKER pro tempore. Under the Speaker's guidelines, the Chair is not recognizing the gentleman from Pennsylvania for that purpose at this time.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. HOYER) to revise and extend their remarks and include extraneous material:)

Ms. WOOLSEY, for 5 minutes, today.

Mr. HASTINGS of Florida, for 5 minutes, today.

Mr. SPRATT, for 5 minutes, today.

Mr. SHERMAN, for 5 minutes, today.

(The following Members (at the request of Mr. TOOMEY) to revise and extend their remarks and include extraneous material:)

Mr. MANZULLO, for 5 minutes, today.

Mr. JONES of North Carolina, for 5 minutes, today.

Mr. DELAY, for 5 minutes, today.

Mr. MICA, for 5 minutes, today.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. HOYER.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 335. An act to amend chapter 30 of title 39, United States Code, to provide for the nonmailability of certain deceptive matter relating to sweeptakes, skill contests, facsimile checks, administrative procedures, orders, and civil penalties relating to such matter, and for other purposes; to the Committee on Government Reform.

SENATE ENROLLED BILL SIGNED

The SPEAKER announced his signature to an enrolled bill of the Senate of the following title:

S. 880. An act to amend the Clean Air Act to remove flammable fuels from the list of substances with respect to which reporting and other activities are required under the risk management plan program, and for other purposes.

ADJOURNMENT

Mr. GANSKE. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o'clock and 59 minutes p.m.), the House adjourned until tomorrow, Wednesday, August 4, 1999, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

3381. A letter from the Secretary of Agriculture, transmitting the annual Animal Welfare Enforcement Report for fiscal year 1998, pursuant to 7 U.S.C. 2155; to the Committee on Agriculture.

3382. A letter from the Acting Administrator, Agricultural Marketing Service, Department of Agriculture, transmitting the Department's final rule— Tart Cherries Grown in the States of Michigan, et al.; Decreased Assessment Rates [Docket No. FV99–930–3 IFR] received July 28, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3383. A letter from the Animal and Plant Health Inspection Service, Congressional Review Coordinator, Department of Agriculture, transmitting the Department's final rule—Limited Ports; Memphis, TN Sec.Docket No. 98–102–2] received June 24, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3384. A letter from the Administrator, Agricultural Marketing Service, Department of Agriculture, transmitting the Department's final rule—Grapes Grown in a Designated Area of Southeastern California and Imported Table Grapes; Revision in Minimum Grade, Container, and Pack Requirements [Docket No. FV98–925–3 FIR] received July 16, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3385. A letter from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting the Department's final rule—Licensing Requirements for Dogs and Cats [Docket No. 97–018–4] (RIN: 0579–AA95) received July 16, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3386. A letter from the Animal and Plant Health Inspection Service, Congressional Review Coordinator, Department of Agriculture, transmitting the Department's final rule—Noxious Weeds; Permits and Interstate Movement [Docket No. 98–091–1] (RIN: 0579–AB08) received July 26, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3387. A letter from the Congressional Review Coordinator Animal and Plant Health Inspection Service, Department of Agriculture, transmitting the Department's final rule—Cut Flowers [Docket No. 98–021–2] received July 16, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.